Juvenile Jurisdiction Policy and Operations Coordinating Council

Service Descriptions and Recommendations

December 15, 2008

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Juvenile Jurisdiction Justice Policy and Operations Coordinating Council Services Subcommittee

Executive Summary

The Juvenile Jurisdiction Policy and Operations Coordinating Council created a services subcommittee that began meeting in January, 2008. The primary purpose of the services subcommittee was to develop service priorities for court involved youth affected by the Raise the Age transition.

Building on the previous service recommendations of the JJPIC, the JJPOCC services subcommittee developed as set of service priorities that assume, incorporate, and enhance the JJPIC service recommendations. As a first step in this development process, the services subcommittee developed a results-based accountability (RBA) model for justice involved youth age 16-17. This model served to anchor the committee work in the important quality of life results the committee identified for this population. These results are:

- All CT children at risk of justice involvement or justice involved will realize their full potential and live safe and independent lives
- All state residents are safe and have a fair and responsive juvenile justice system

The services subcommittee then conducted a services inventory to identify the services currently provided by key partners to court involved youth age 16-17 (in the early stages, there was also some identification of prevention services the discussion of which ultimately was ceded to the prevention subcommittee). Using this inventory and building on the JJPIC services recommendations as well as information on critical protective factors[1], services and client data from the Court Support Services Division and the Department and Children and Families, several key service priorities were identified, including:

- **Behavioral Health**, including:
  - Substance Abuse Treatment
  - Mental Health Treatment
  - Sex Offender Treatment
  - Cognitive-Behavioral Treatments
- **Basic Needs, Including Safe housing**
  - Transitional housing
  - Residential behavioral health treatment
- **Educational/Vocational Services**
- **Positive Youth Development**
  - Apptiitude Testing
  - Life skills
  - Youth leadership
  - Youth centers
  - Pro-social activity

[1] Turner, Michael, "Examining the Cumulative Effects of Protective Factors: Resiliency Among a National Sample of High-Risk Youths," **Journal of Offender Rehabilitation,** Vol. 46 (1/2), 2007. Pp. 81-111.

The committee also identified several cross-cutting services delivery principles, as well as some opportunities for service integration and system development. In the detailed discussion that follows, additional services detail and possible phase in approaches are recommended.

The above services recommendations were presented to the full JJPOCC on September 22, 2008. At that meeting the JJPOCC co-chairs asked the primary agencies (DCF, CSSD, SDE, and DHMAS to provide information clarifying the specific services that would be provided and the cost of those services, together with current capacity. This information was developed during the months of October and November, 2008 and presented to the co-chairs in early December. The following services information reflects the submissions of these agencies. Table 1 shows summary budget information submitted by those agencies for 16 and 17 year-olds.

Table 1.

	Current*	2009-2010 Additional	2010-2011 Additional	2011-2012 Additional
Behavioral Health	$34,169,963	$4,438,499	$8,366,555	$9,780,075
Basic Needs	$1,816,302	$848,881	$3,155,934	$5,904,085
Education / Vocational	$3,207,000	$2,211,607	$3,923,571	$4,591,641
Positive Youth Development	$10,352,495	$2,710,084	$5,258,824	$7,595,098
System Enhancements		$437,500	$475,000	$475,000
Residential Care	$12,673,059	$1,978,715	$6,299,702	$6,282,107
Other		$780,000	$1,045,000	$1,310,000
Sub Total	$62,218,819	$13,405,286	$28,524,586	$35,938,006
Prevention Proposal		$3,500,000	$7,400,000	$7,400,000
Total		$16,905,286	$35,924,586	$43,338,006

*includes both JJ and Youth Current Funding

Overview

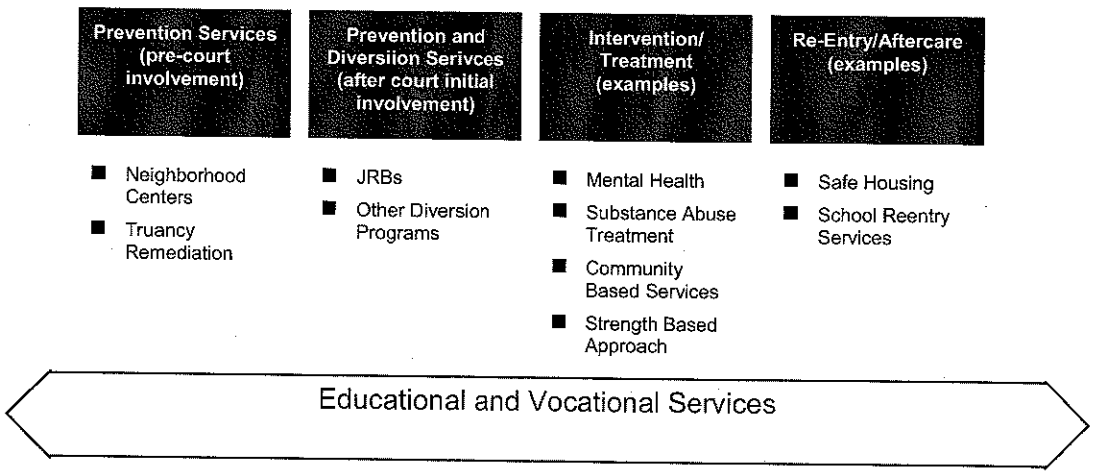
The Juvenile Justice Policy and Operating Coordinating Committee (JJPOCC) created a services subcommittee in January, 2008 to develop services recommendations as part of the Raise the Age transition effort.

The committee, comprised of state executive branch and judicial branch staff, as well as private sector representatives, met 9 times between February 2008 and July 2008 in order to:

- Develop a results-based accountability model for Raise The Age for use as a strategic framework for services discussions;
- Create an inventory of current and proposed services;
- Identify service needs, potential service gaps, and opportunities for service integration

It was necessary for the prevention subcommittee and the services subcommittee to create a somewhat artificial division of labor as the services design evolved. Both committees recognized that there was a continuum of services, from prevention through services to court involved youth during and following court involvement. See the diagram of the overall service design below.

Overall Services Design



The prevention committee has developed recommendations regarding prevention services in three areas: Neighborhood services, truancy remediation, and diversion programs. ***The services committee has focused their recommendations on services to court involved youth, from prevention through re-entry, including vocational / educational services.***

The JJPOCC Services subcommittee reviewed current research in order to ensure that best practices dictate our proposed practice whenever possible. We have also recommended the embedding of evidence based principals and promising practices in programs for which best practices have yet to be developed. However, it should be noted

that most research does not distinguish sixteen and seventeen year olds from younger adolescents, as in most states youth are already part of the juvenile justice system, rendering such distinctions meaningless. Moreover, even when known principals are in place, quality implementation is critical to successful outcomes. Furthermore, these service recommendations stem from a combination of predictions and precedent, and is intended to provide a general service delivery framework more than to suggest specific approaches or units of service. It will be important to evaluate this process as it develops and to remain flexible in approach. Corrective changes should be proposed based on the collective experience of those involved in the transition.

The Department of Children and Families and the Court Support Services Division of the Judicial Branch convened a broad stakeholder strategic planning initiative that culminated in a report first published in 2006, and a Results Based Accountability (RBA) document in 2007. Currently DCF and CSSD are coordinating the Executive Implementation Team (EIT) comprised of leaders from multiple state agencies, parents, and advocates to oversee the implementation of The Connecticut Juvenile Justice Strategic Plan and to coordinate all juvenile justice system-related efforts. The EIT is prioritizing the implementation of strategies and programs to meet the needs of court-involved children and youth and their families, and is monitoring ongoing efforts to meet the population and program measures defined for the juvenile justice system. The EIT will monitor system performance through the use of data and will influence funding priorities.

In an effort to gain perspective from a wide variety of stakeholders on its Raise the Age Plan, the Department of Children and Families held a series of Listening Sessions. Sessions have been held in numerous parts of the state, and have been held specifically for different groups (families, youths, advocates, and providers) so that the perspective of each group could be heard. The sessions have provided DCF with strong feedback regarding perceived needs, DCF's proposed services, a significant number of programmatic and systems change recommendations, and gave the constituent groups the opportunity to review, comment on, and impact DCF's plan.

The Services sub-committee proposes to host a series of follow-up Listening Sessions, building on the DCF sessions, in order to gain feedback and guidance regarding implementation of services and the roll-out of Raise the Age processes and procedures.

There are instances when a delinquent act committed before an individual's18th birthday may lead to conviction and commitment as a juvenile delinquent after an individual's 18th birthday. The Department of Children and Families' understanding of current statutes is that it does not have the ability to enforce court orders on individuals over the age of 18. Further, current licensing precludes DCF from admitting individuals over the age of 18 into programs licensed for children. While current practice includes allowing individuals who turn 18 while actively participating in treatment to complete that treatment on a voluntary basis, admission of adults, and enforcement of court ordered conditions are outside of DCF's current statutory authority and licensing ability.

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The Department of Mental Health and Addiction Services has a limited amount of services appropriate for some court-involved young adults, however, these services are heavily utilized, and only appropriate for those individuals who meet DMHAS criteria (significant mental health and substance issues).

Other state agencies operate programs designed for adult criminal offenders, and are therefore not considered appropriate or accessible for young adults committed as delinquent youths.

In order to determine which agency, or agencies, should be charged with providing services and supervision to the over-18 committed delinquent population, an Attorney General opinion has been requested.

Juvenile Jurisdiction Justice Policy and Operations Coordinating Council Services Subcommittee

Subcommittee Participants

(titles to be added)

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Results-Based Accountability Model

Overview of RBA Development Process

The first task of the services subcommittee was the creation of a results-based accountability model[2] to guide the efforts of the committee and to ensure alignment of the service model with the desired results for 16-17 year olds at the population level. As is shown in the Appendix B, of the RBA model starts with the articulation of the desired quality of life results. In the case of the JJPOCC services subcommittee, two results statements were developed in order to represent both the successful and trouble-free youth desired result as well as a safety and fairness result. Once these results were articulated, indicators (a few headline indicators and several secondary indicators) were selected in order to assess progress of the state toward these desired results. Following that, the strategic areas described below were used to help think about important system development measures as well as common program measures, which were also identified during the model building process. At this stage, the model is now fairly complete, although it is a living document always open for revision and enhancement. Moving forward, the efforts of the committee will be grounded in and guided by the RBA model, ensuring alignment of the emerging service model with the ultimate quality of life results that this transition is intended to enhance and foster.

The following proposed strategic service areas were developed to help talk about and categorize the types of services that contribute to the quality of life results for 16 and 17 year olds (as defined in the RBA model).

Proposed strategic service areas and respective definitions.:

Prevention:
Services intended to prevent youth from becoming court involved, either prior to initial court involvement or subsequent to initial court involvement.

Diversion:
Services intended to help youth avoid court after they have had initial contact with the justice system (arrests, referred to court).

Intervention:
Services [other than diversion, clinical treatment or education/vocational services] intended to address specific challenges faced by youth once youth have had initial contact with the justice system.

Treatment [clinical]:
Clinical services intended to address intensive challenges faced by youth once they have had initial contact with the justice system.

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[2] Friedman, Mark, 2006. Trying Hard Is Not Good Enough. New York: Tafford Press.

Education/Vocational:
Services intended to help youth stay in school, succeed in school, gain basic skills, and/or gain vocationally oriented skills.

The Youth Future's Committee recently issued a report, Connecticut's Framework for Positive Youth Development[3], that includes a series of positive youth development assets need for youth to be ready for work or college at age 21 (See related document). These assets are divided into six main categories:

- Basic Needs
- Physical Health
- Positive Social/Emotional Development
- Job Readiness/Financial Literacy
- Formal Education

An extensive inventory of services is being developed by the committee. Each participating agency was asked to submit an inventory of services categorized using the above categories. The inventory identifies each positive youth development asset category to which it contributes. The inventory provides a means to determine the alignment of the services with the quality of life results in the RBA model, the strategic areas (which are very similar to the areas in the joint CSSD/DCF strategic plan), and the positive youth development model. The population level indicators and system and program performance measures contained in the RBA model will assess the progress of the state toward the quality of life results as well as the outcomes of system development and program enhancement efforts.

Linkage to DCF-CSSD Joint Strategic Plan

Efforts have been made to build on the work of the current Joint Juvenile Justice Strategic Plan (JJSP) wherever possible. The results statement for this project builds on the results statement for the JJSP, and the wide-ranging scope of that plan has been embraced by all three sub-committees of the JJPOCC. Further, interagency linkages and efforts that were developed through the JJSP process have been built on in this group, and in both of the other sub-committees.

Next Steps Required In Development of RBA Model

- Alignment with Joint Juvenile Justice Strategic Plan
- Development of a "report card" for Raise The Age, using the indicators [and possibly system development measures] from the RBA model
- Pilot application of RBA model to individual services within specified agencies
- Applying RBA contracting principles [such as those in CPPC contracting protocol] to Raise The Age contracted services

[3] Connecticut Youth Future's Committee, 2008, "Connecticut's Framework for Positive Youth Development."

Service Needs

Assumptions

The committee began with a set of basic working assumptions regarding the projected annual number of 16-17 year olds to be served. These projections are necessarily very inexact, due to the difficulty of anticipating how the transition will occur from a client flow perspective. However, the basic working assumptions included:

- Roughly 2000 16-17 year old court-involved youth requiring services
- Roughly 250-300 16-17 year old youth committed to DCF
- A typical delinquency commitment to DCF is expected to last for approximately 2 years. A number of these youth will be committed just before or after their eighteenth birthday so services will be needed until nearly the twentieth birthday for some individuals. This will have a significant impact on the existing service system for adults.

Substantial previous work has been done on the issue of service needs for 16-18 year olds. As part of previous JJPIC work [4*5], as well as in developing budget requests for FY 09 and FY 10, DCF and CSSD have used some basic assumptions in estimating the numbers of 16-18 year old youth that would be served by these agencies.

DCF also shared results from analyses of the comprehensive multi-system assessment (CANS) completed for all court-involved youths for whom residential or group home care was sought in 2007, and results of The Youth Compas - a fourth-generation risk and needs assessment tool, specifically designed for administration to children and youths currently incarcerated or placed out of the community. The Youth Compas was administered in 2007 to youths incarcerated at Manson Youth Institution, York Correctional Facility, and those 16 and 17 year olds on Juvenile Parole.

In order to better understand the treatment needs of the older adolescents likely to be committed, a comparison of CANS and Youth Compas scores was undertaken, and identified the following treatment areas:

- Family issues;
- Educational issues;
- Vocational training and opportunities;
- Recreational opportunities and services;
- Mental Health treatment;
- Substance Use treatment;
- Reduction of high-Risk Behaviors;
- Alternatives Criminal behavior;
- Lack of Neighborhood Safety.

[4] Connecticut Juvenile Jurisdiction Planning and Implementation Committee, Final Report, February 12, 2007.

[5] Horby-Zeller, Connecticut Service Needs Study, 16-17 Year Old Court Involved Youth, Final Report, January 29, 2007.

CSSD also provided information on the problems faced by youth in their system These include:

- Anti-Social Peers
- Family/Marital
- Attitude
- Emotional
- Substance Abuse
- School Attendance/Behavior
- Unsafe Neighborhoods

Partners

The following partner services are included in the services inventory [contained in Appendix B]:

- CT Judicial Branch, Court Support Services Division
- CT Department of Children and Families
- CT Department of Education
- CT Department of Mental Health and Addiction Services
- CT Department of Labor
- CT Workforce Investment Boards
- Youth Service Bureaus
- Municipal Police Departments

Service Recommendations

The Services Subcommittee of the JJPOCC recommended cross-cutting service delivery principles which are presented below. Following those principles, opportunities for service integration, resource leveraging and system development are presented. Service descriptions, aligned with the Services Subcommittee's priority service categories are then presented.

Crosscutting Service Delivery Principles

1. Customize service mix for each child based upon assessed strengths and needs.

While cost concerns often suggest purchasing specific kinds of services in bulk, this often leads to children being "force-fit" into services that may not be appropriate for them. To the extent possible, the service mix for each child should be based upon assessed strengths and needs, and services should be procured using a "just in time approach" (services procured as needed rather than large numbers of slots procured in anticipation of need) to calibrate available services with service need.
As with the recommendations from the Joint Juvenile Justice Strategic Plan, when families and communities are involved as partners in planning for their children, services are child-specific and family-driven, and are more likely to build on the child's and family's strengths, and specifically target their needs in an individualized manner.

2. Encourage grass-roots service planning and service provision

While state-level service planning is necessary, grass roots service planning and service provision should be encouraged. State level planning efforts should include participation from local grass roots organizations, and be flexible enough to allow for the development of local plans that respond to local needs. This is one area where the recommendations of this group are aligned with the Joint Juvenile Justice Strategic plan and its implementation of Local Interagency Service Teams to inform and guide statewide planning efforts

3. Encourage support of faith-based services

Faith-based service provision should be encouraged and supported. Needs that are amenable to faith-based service provision should be identified, and the processes required to allow faith-based service provision should be streamlined and simplified.

4. Encourage **strength based** and **family based** approaches

Services designs should allow for the use of strength-based and family based approaches. Customizing services based upon the assessed strengths and needs of the child would identify when family-based services are appropriate, and strength-based approach would build upon the strengths identified through the assessment process. Family-centered treatment is important when working with offenders. There is ample empirical evidence to suggest that family problems (or risk factors) increase the likelihood of a child or youth being referred to court. Because even dynamic family risk factors are sometimes intractable but resiliency can be built when protective factors are strengthened, the objective of family-focused programs should thus be to not only decrease existing risk factors, but to also increase family protective mechanisms. Models with such approaches have proven effective in CT and across the country with interventions such as MST, FFT, BSFT and others. Because treatment tends to be short-term and families endure, family- or ecologically-oriented work is also an important means of sustaining change after formal supervision and services have ended.

5. Encourage services following the child

In order to appropriately provide for the 16 and 17 year old youth entering the system with significant serious emotional or behavioral disorders, it is important to institute a wraparound process and system of care where the money actually follows the child.

Wraparound is an individualized process that builds on the child's and family's strengths. Services are provided through teams that link children, families, foster parents and their support networks with child welfare, health, mental health, educational and juvenile justice service providers to develop and implement comprehensive individualized service and support plans.

6. Ensure age and gender appropriate services

In both the procurement and monitoring of services, ensure that services are both age and gender appropriate. Specifically, create practice standards for gender-responsive, culturally/linguistically competent and developmentally-appropriate evaluation and treatment services, and create programs targeted to specific sub-populations based on documented needs; these programs will be age appropriate, gender-responsive, and culturally competent to ensure gender responsive services, create policies and processes for the certification and credentialing of gender-responsive programs for girls; develop and implement gender-specific assessments for all court-involved girls, and in response to identified needs, create new programs and expand access to existing programs as necessary.

7. Ensure trauma-informed services

In the design, procurement and monitoring of services, ensure that services are trauma-informed.

8. Align service mix with Joint Juvenile Justice Strategic Plan

As referenced in other parts of this document, DCF and CSSD have led a multi-agency joint strategic plan that provides for the on-going development and management of service delivery and design. See attached copy of the plan. Many element of this report are based on the JJSP, but an ad hoc work group with representatives from both efforts will continue to work to ensure that service elements of this plan are developed within the structure of the JJSP, and that if necessary, elements of the JJSP will be expanded to Encompass all elements of this plan.

9. Expand use of community integration funding

Availability of funds that can be used in a flexible way provides a mechanism for customizing the service mix for the needs of the child, and allows for the piloting of innovative approaches on a limited scale. Initial data on the use of contracted flexible funding indicates that for behavioral health populations, detention-involved children, and probation-involved children, flexible funding is an extremely cost-effective way to deliver targeted and individualized services to children, youth, and their families which would not otherwise be available.

Opportunities For Service Integration and Resource Leveraging

The following are opportunities for cross-agency service integration and resource leveraging:

- Substance Abuse Programs
- Assessments
- System Evaluation
- Data Sharing
- Services from non-educational agencies right at the schools
- Joint treatment planning
- Underutilization of Juvenile Review Boards
- Kid care services
- Integration with existing kid care services

Of these, assessment, system evaluation, and data sharing are all critical areas of integration. The possibility of using a modular **assessment** approach should be considered, where common data elements are collected one time and available as needed to all agencies that may deliver services to the child. Customized modules for particular service streams (e.g., assessment upon initial court involvement, assessment upon commitment, assessment at probation or parole) could be created as stand-alone modules that build off of the common core data elements. Connecticut is one of four states selected in a highly competitive process by the John D. and Catherine T. MacArthur Foundation to participate in an action network to improve mental health services for young offenders. Connecticut is now one of 12 states providing leadership as part of MacArthur's $120 million Models for Change, a national initiative to reform juvenile justice across the country. As part of the network, Connecticut is working to find new ways to identify and treat children and youth involved in the juvenile justice system who have serious mental health needs. Exploring improvements to assessment approaches is part of this work.

System evaluation is another area of possible integration and resource leveraging. Evaluation of programs of similar type, or evaluations of services used by multiple agencies, should be coordinated, and the resources for those evaluations pooled to allow for the most effective use of those resources and the generation of more comprehensive evaluation information.

Data sharing is the third priority area for service integration and resource leveraging. The system should work toward creating an identification protocol so that records from one part of the system can be matched with outcomes collected by other parts of the system. Templates for effective memorandums of agreement for data sharing, client

waiver approaches, and aggregate report formats should be developed and shared, and an on-going data sharing workgroup should be created to support and monitor these efforts.

Work cross agencies and systems towards maximization of Federal Medicaid Reimbursements

Many states have worked creatively and collaboratively with their Medicaid agency in creating definitions and crafting waivers so that they can take full advantage of federal dollars, freeing up state dollars for home- and community-based services now largely funded by state dollars. Connecticut's child and family serving agencies should get together to determine how to ensure programs and systems are set up to ensure that whenever possible, Federal funding opportunities are maximized. Funds "reclaimed" through these efforts should be reallocated to those same agencies to ensure a broader, fuller range of services for the youth and families they support.

System Development Priorities

The committee also identified several system development priorities in order to ensure that services are administered, implemented, monitored and evaluated in an efficient and effective manner

- Capacity Building

The training of agency and provider staff, particularly in priority service areas, is critical. Also, staff should be aware of how the cross-cutting service delivery principles are applied on a day-to-day basis.

- Staff Turnover Reduction

The development of strategies for reducing staff turning is critical if the availability of quality, fully staffed services is to be sustained.

- Succession Planning

Planning for the potentially large number of state staff that are retiring in the next few years, in both service and management positions, needs to be begin now. A succession plan for key management staff, and an approach to ensuring critical services are fully staff need to be developed.

- Quality Assurance

An often over-looked part of implementation, quality assurance (particularly frequent program monitoring) is a crucial part of managing program transitions and introducing new service strategies.

- Evaluations

While the value of evaluation is self-evident, it is often underfunded. Process and outcome evaluations of different services are critical to refine service strategies and improve program outcomes. Longer term evaluations, with process, outcome and impact components and participation from multiple partners, should be designed and funded early in the transition process.

Department of Children and Families Services Descriptions

DCF's Phase-In Plan
Based on reviews of Connecticut and national data, and in-depth analyses of the needs and risks of court-involved 16 and 17 year olds, DCF is estimating that approximately 198 16-and 17-year olds, will be committed delinquent each year. We anticipate that boys will account for 150 of the commitments and girls will account for 48 of the commitments.

After a two-year phase-in period, based on commitments equally spread over the course of each year, and with average commitments of 24 months (including re-commitments and extensions), approximately 396 youths are anticipated to be committed at any given time, and in addition to the current Parole caseload.

DCF's budget request is based on these numbers, and is phased-in over three fiscal years to allow for ongoing monitoring of the numbers of commitments and the needs of the population, and to gradually increase service capacity as the size of the population increases over the course of two full calendar years.

Service categories below are organized in the format designed by the Services Sub-Committee of the JJPOCC in order to be easily translated across agencies.

SERVICES

Behavioral Health

In home services (IICAPS, FFT, MDFT)
IICAPS is a promising practice that addresses the needs of families with children or youth with complex psychiatric disorders. Target populations include children being discharged from psychiatric hospitalization and children at imminent risk of hospitalization. The primary focus is on psychiatric symptoms within an eco-systemic model. Each IICAPS team serves 8 children at one time, and the length of treatment is usually up to 6 months.

Functional Family Therapy (FFT) is a short term evidence-based, strengths-based program that addresses problems ranging from mood disorders to conduct disorder. The primary focus is on the function of maladaptive behavior within the family structure, problem-solving, encouraging and supporting positive relating to family members. Target populations include families with limited resources, treatment failure, range of diagnoses, multiple system involvement. The length of treatment generally ranges from ten to twenty weeks.

Multi-Dimensional Family Therapy (MDFT) is an evidence-based family therapy program that focuses on adolescent development, family systems issues and extra-

familial systems (courts, school, etc.) and is a relationally based therapy. Target populations include those children who are at risk for substance abuse or substance abusing, and living at home with, or returning to, a primary caregiver. Children/Youths often have co-occurring disorders, and treatment ranges from four to six months.

Substance abuse treatment

Multi Systemic Therapy (MST) is a short-term evidence-based program designed for Children/youth with delinquent behavior and/or Substance Abuse problems living at home or returning home to a primary caregiver. The primary focus upon adolescent development, substance abuse, peer influences, and parenting. Clients are generally 11 to 18 years old, and the length of treatment is four to six months.

Family Substance Abuse Treatment Service (FSATS) is a longer-term service, combining two evidence-based practices (MDFT and Engaging Parents) for children in or recently in detention and who are at imminent risk for residential treatment, and where there is evidence of parental substance abuse. Focus is on family systems issues child and parental substance abuse, and extra-familial systems (courts, school, etc.) The program is designed for adolescents 11 to 17.5 years old, and is a twelve-month program.

Short Term Inpatient Treatment is currently provided through the New Choices program at the Children's Center. The program serves 12 court-involved adolescents at any one time, and is a 45-day program. The program is utilized predominately by juvenile probation, often in conjunction with DCF staff, and can be used at the beginning of treatment for those adolescents who need to be briefly removed from the environment at the onset of treatment, and also as a mid-treatment response to adolescents who are unable to remain substance free while participating in community-based treatment. It is evident from the risk and need analyses of the youth population that increased access to short term inpatient treatment will be needed for this population.

Recovery Management applies a chronic disease management approach to embed regular systematic assessment, re-evaluation of treatment and discharge plans to meet emerging or continued needs, and provide opportunities for ongoing support for youth and their families to sustain treatment gains and intervene early if there are signs of relapse. Gains achieved through sustaining recovery for adolescent substance abusers are likely to be reflected in reduced needs for long-term substance abuse treatment, decreased entry or recidivism into the criminal justice system, and higher educational achievement and employment both during adolescence and adulthood

This program will be especially important for juvenile parole because it is during the transition from intensive treatment back to community functioning that most adolescents experience relapse. Recovery Management is a very promising practice that is receiving

significant national attention due to the necessity of addressing the very high rates of adolescent substance abuse relapse rates.

JJIE

Juvenile Justice Intermediate Evaluations (JJIE) services were developed to reduce the wait for admission to Riverview Hospital for court-involved children requiring a comprehensive behavioral health evaluation, and who don't need to be hospitalized during that evaluation. JJIE evaluations are intensive, outpatient, multidisciplinary mental health assessments of court-involved children and/or youth ordered by the Superior Court for Juvenile Matters. Through the use of multidisciplinary teams, private providers deliver a range of formal evaluation and assessment services during a10 day evaluation period in order to complete a comprehensive summary report on each child and family. The formal evaluation and assessment services are reviewed, and a comprehensive recommendation is developed through a team conference including family members, JJIE evaluation team members, Probation and DCF representatives, service providers, and other participants as appropriate. Since the implementation of the JJIE, combined with other measures, waits for admission to Riverview for court-ordered evaluations, have declined drastically.

The JJIE is a particularly important piece of the DCF plan in that it serves court-involved children in both a pre-trial and sentenced phases of their court involvement, and is specifically designed to decrease utilization of Riverview Hospital for Children and Youth, and to formulate realistic plans for community-based services whenever possible. This allows more children to remain at home during the evaluation instead of being evaluated in the hospital, and it also diverts children from residential treatment by working with the family, agencies, and providers to develop comprehensive community-based treatment plans.

Currently 16 and 17 year olds in the criminal system are not routinely screened for behavioral health issues, and judges in the criminal system do not have the ability to order these adolescents for inpatient psychiatric evaluations. Because of the increase in psychiatric diagnoses beginning around age 16, combined with juvenile judges' ability to order evaluations for this population, DCF is anticipating a significant increase in referrals for this important and effective service.

Homecare

The program is jointly funded by the Department of Children and Families and the Court Support Services Division of the Judicial Branch. It was developed to provide a resource for detention-involved children requiring psychotropic medication as a condition of release and return to the community. The model, designed as a "bridging service" was developed on the premise that an advanced practice nurse (APN) and a child psychiatrist would go as a collaborative pair, into the FQHC system to deliver child psychiatric services. The FQHC system contracts for the APN and Child Psychiatrist services from the University. All staff are employees/faculty of the University of CT with requisite benefits and malpractice insurance coverage. The average length of time from first contact to intake is 14 days. Each case is triaged according to acuity. In the first years of

the program, all referred children were required to have been in juvenile detention per the requirements of the consent decree. Over the years the program requirements have broadened to include any youngster involved with juvenile justice, youth ages 16-18 involved with juvenile parole or adult probation, and children from Families With Service Needs (FWSN). About 20% of all accepted referrals involve youth between the ages of 16 and 18. This is estimated to increase as Connecticut prepares for the Raise the Age initiative based on analyses of the behavioral needs of this older population.
HomeCare has been so successful with its federal reimbursement efforts that we have been able to increase the number of clients served from 100 to 200 per year with the same amount of state agency funding.

Sex Offender Treatment (community based)
Community-based services for committed delinquents on sex offender supervision who have successfully completed residential treatment, and are returning to the community are an important way to assist juvenile parolees continue treatment and engage in appropriate and legal behaviors, while still under the supervision of a specialized parole officer who has received additional training in sex offender treatment and supervision. The juvenile parole division utilizes a specialized type of Multi Systemic Therapy for Problem Sexual Behavior (MST-PSB) that is quite successful with this population. In addition, individual counseling/therapy, The Problem Sexual Behavior Clinic at the Connection Inc., and the Clifford Beers, JOT Lab services are utilized by juvenile parole for aftercare and reentry services for this population.

Community engagement and reintegration funds
These funds are designed to meet the needs of children and youth and their families on an individualized basis. Funds are available for committed delinquents and are used to access services and goods that will help the child return to, and successfully remain, in the community. Requests are made by the Juvenile Parole Officer or Social Worker and approved by the Parole Program Supervisor. A contractor serves in a fiduciary role specific to the payment for certain goods or services provided to children and their families on behalf of the Department or CSSD. The Contractor monitors the funds distributed through the contract and produces individual, local, and summary reports regarding statewide utilization by both dollars and types of expenditures.

Most often, these funds are combined with contracted services to meet individualized and specific needs of children and families to ensure their success in the community. Originally launched for the juvenile justice population through the Emily J. Settlement Agreement, use of the funds has been monitored and studied, and the Emily J. Quality Assurance study demonstrates that when social workers, probation officers, and juvenile parole officers can access these funds for the benefit of children and families struggling to succeed in the community, we see improved rates of success, and decreases in recidivism.

Basic Needs

Community Engagement and Reintegration Funds
These funds are designed to meet the needs of children and youth and their families on an individualized basis. Funds are available for committed delinquents and are used to access services and goods that will help the child return to, and successfully remain, in the community. Requests are made by the Juvenile Parole Officer or Social Worker and approved by the Parole Program Supervisor. A contractor serves in a fiduciary role specific to the payment for certain goods or services provided to children and their families on behalf of the Department or CSSD. The Contractor monitors the funds distributed through the contract and produces individual, local, and summary reports regarding statewide utilization by both dollars and types of expenditures.

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Group Home and Transitional Living Programs
Preparing Adolescents for Self Sufficiency (PASS) programming is conducted in a group home with a structured program to maximize individual outcomes and transition toward self-sufficiency. These group homes stress education, pre-employment skill development and independent living skills.

Supportive Work, Education & Transition Program (SWETP) is a community-based, staffed apartment program serving committed youths. The program focuses primarily on the developmental issues associated with the acquisition of independent living skills. These apartments are congregate living settings with 24/7 staffing and mandatory programming for all residents. Currently these programs are designed for adolescents transitioning from the child welfare system and preparing for successful adulthood and working toward higher education. For a juvenile justice population, services would be modified slightly, and focus would include job acquisition and retention, and post secondary technical training.

Community Housing Assistance Program (CHAP) is a semi-supervised, subsidized, housing component for youth ready for less supervision and more independence. The goal of this program is to increase competence, self-reliance and self-sufficiency as youth transition into the least restricted out of home placement within the agency.

Shared Living Providers insure the stability, safety, health, and welfare of those individuals under their care. Shared Living arrangements provide care in a manner that maximizes the individual's dignity and quality of life and most closely replicates a private home experience. Providers are professionally trained, compassionate caregivers

who are well matched with the individual in their care. For those older youths who do not need residential or group home care, but who also are not ready to live on their own, this may be an important new program. While this is a service that is community-based and very successful with older juvenile delinquents in other jurisdictions, it is not yet established in Connecticut, and DCF is actively investigating this promising practice.

Vocational Education Programming

Support Team for Educational Progress (STEP Program) can be short or long-term education advocacy and programming based on individualized education plans (IEP) and reintegration plans, including educational record reviews, assessments, credit history, monitoring of IEP goals and objectives, appropriate course placement. Individualized transitional alternative education, parent advocacy, substance abuse treatment, life skills training and social skills employability development are also part of this program. For youths on juvenile parole who successfully complete high school/high school equivalency, post-secondary education may be pursued through the STEP Program.

Virtual Learning Academy (VLA) is an online high school course of study accessed on an individualized basis, and is usually accompanied by educational intensive case management for children and youths unable to participate in STEP due to geographical issues. Initial designs for this service would include an educational consultant or case manager combined with Virtual Learning Academy (VLA) and flex-funded enhancements.

Work/Learn Services are funded by DCF, sometimes in conjunction with other state agencies, and are designed to assist adolescents gain job readiness skills and on-the-job training to prepare them for successful integration in to the working world.

Positive Youth Development

Community Engagement and Reintegration Funds
These funds are designed to meet the needs of children and youth and their families on an individualized basis. Funds are available for committed delinquents and are used to access services and goods that will help the child return to, and successfully remain, in the community. Requests are made by the Juvenile Parole Officer or Social Worker and approved by the Parole Program Supervisor. A contractor serves in a fiduciary role specific to the payment for certain goods or services provided to children and their families on behalf of the Department or CSSD. The Contractor monitors the funds distributed through the contract and produces individual, local, and summary reports regarding statewide utilization by both dollars and types of expenditures.

Most often, these funds are combined with contracted services to meet individualized and specific needs of children and families to ensure their success in the community. Originally launched for the jj population through the Emily J. Settlement Agreement, use

of the funds has been monitored and studied, and the Emily J. Quality Assurance study demonstrates that when social workers, probation officers, and juvenile parole officers can access these funds for the benefit of children and families struggling to succeed in the community, we see improved rates of success, and decreases in recidivism.

Other Relevant System Enhancements

As DCF continues to refine the details of the proposed service delivery system, DCF staff members will build a Quality Assurance effort that will evaluate the impact and outcomes of the various interventions detailed in the plan, as well provide some indication of overall outcomes for children and youths participating in services provided through the Raise the Age initiative.
This effort will not only ensure that quality services are being provided, but will also provide the State of Connecticut with important information that can guide future decision making and resource allocation.

The Quality Assurance effort will serve not only to mark the progress towards the identified goal of children and youths moving through the systemic change provided by the Raise the Age initiative, but it will also serve to provide important quality assurance data that will be reported back to DCF and other system partners to track the outcomes of interventions and guide ongoing and future implementation of interventions for children, youths, and families. In addition to the quantitative data, the effort will include descriptions of progress, identification of challenges and barriers to successful implementation of services and systems change, as well as recommendations for areas of improvement.

DCF, CSSD, and other private and public partners, have been working together for approximately four years to develop and implement a joint strategic plan that has begun to guide our treatment of children and youths in the juvenile justice system, and their families. The plan includes specific recommendations for staff training and development. DCF is fully committed to this plan, and intends to be guided by the joint work on training guidelines and curricula for this work.

Approximately 5% of funding designated for contracted services through the Raise the Age Initiative will be identified specifically for Quality Assurance and Training efforts.

Residential Care

Residential Treatment is provided by DCF for those children and youth who are committed delinquent, and have been determined to need treatment out of their home communities, but do not need secure treatment. There are a number of different specialties and focus areas of residential treatment for this population. While there are a core group of treatment providers who more regularly serve the juvenile justice

population, depending on a child or youth's needs, he or she may be placed in any of the programs utilized by DCF.

Currently, DCF staff is working with a core provider group to determine what programmatic changes need to be made for this slightly older population, and how these changes can best be integrated into the exiting system.

Residential treatment is provided with aftercare and reentry services in mind, and as part of the treatment plan. The services identified in the Basic Needs section of this document, as well as the community-based services identified herein will be utilized as the aftercare and reentry services for this population.

CSSD Raise The Age Services Budget Narrative and Accompanying Program Description

Behavioral Health:

MST is an evidence- and home- based intervention for high risk children younger than 18 yrs old and their families. Targeting violent, substance abusing and chronic offenders, MST has proven outcomes in recidivism reduction, and is endorsed by OJJDP and the US Surgeon General, among others.

IICAPS in an intensive mental health treatment program for those under 18 and their families. Also home-based, IICAPS serves children at risk of psychiatric hospitalization, or discharging from such, and reduces ED visits. Homecare serves as a bridge for children needing medication management but who are waiting for longer-term treatment, since there is a dearth of child psychiatrists in CT, and waits are therefore common.

Juvenile Risk Reduction Centers offer cognitive behavioral therapy addressing anger management, violence prevention , moral reasoning, social skills, relapse prevention, trauma. Services are available in the home for those clients unable to come to the center due to barriers including transportation, childcare, neighborhood.

Community Engagement and Reintegration Funds are sometimes referred to as flex funds. these dollars leverage client participation by removing other barriers to services. They are often used to assist with basic needs, but also reward goal attainment and link youth to prosocial community activities that endure after program / probation tenure end.

Sex offender treatment is a clinical program that addresses both predatory and reactive sexual offending behavior. Interventions can occur 1:1, or as family treatment, and sometimes includes psychoeducation.

Psychological, psychiatric, substance abuse and sex offender evaluations are conducted by licensed clinicians and assist the court with making appropriate dispositions and treatment referrals. In addition to **Court-Based Assessments**, lengthier clinical evaluations (JJIEs) can also be made, as needed.

With the requested appropriation, CSSD would contract for additional **substance abuse treatment** capacity. Presently available are relapse prevention groups at the JRRCs, and in-patient stays. Services to round out the continuum for clients with needs between these extremes would greatly enhance the system.

Educational and Vocational Services:

The **Work and Learn** programs are sited in NH, Bpt and Htfd, and reflect partnership with CSSD in a DCF contract. Each site serves 20 youth at any given time

CSSD is presently actively engaged in discussion with state agencies, cities and private vendors regarding collaborations that may be developed to ensure access for probationers to **vocationa**l supports / employability skills training and job placement.

Educational advocacy is provided in several juvenile contracted programs, not currently in those serving youth. Funding would permit expansion of educational supports including tutoring and advocacy in additional programs.

Basic Needs:

Basic needs minimally include food, clothing, hygiene products, safe housing, medical insurance and identification. A large number of court involved families have financial difficulties and are challenged with respect to accessing and navigating the system. Failing to address these basic needs would present additional barriers for youthful offenders to achieving or maintaining pro-social lifestyles and an exit from the criminal justice system.

CERF funds permit referral to prosocial activities after probation or program tenure have ended. These on-going supports are critical for sustained change and recidivism reduction.

System Development:

System evaluation enables all stakeholders to know the outcomes of interventions and to make decisions based on data rather than conjecture.

Program staff require **training** in the particular interventions that they deliver, as well as "approach" issues such as motivational interviewing, strengths-based practice, and adolescent development. The contracted service network includes thousands of employees to be trained.

Residential:

CSSD contracts for in-patient **substance abuse treatment** services for youth, and anticipates a need to modify the service network to include additional levels of care. Partnership with DCF in this endeavor may allow for efficiency and is being explored.

ADPs offer a staff-secure alternative to detention for youth who a judge finds can be maintained in this less intense level of care.

State Department of Education Services Descriptions

Educational/Vocational

Program Name: Young Parents Program

Program Description: Provides school-based child-care services and parenting education for young parents, 14-19 years of age. This program is also used in some school districts to teach pregnancy prevention. Program components include: (1) high school education for young parents; (2) child-care services for the children of young parents; (3) parenting education and information on child development; and (4) linkage to other resources in the community.

Program Name: Young Adult Learner Program

Program Description: Provides an opportunity to students in Adult Education programs, ages 16 through 21 years, to participate in a model that offers: enhanced educational programming, comprehensive support services, workforce preparation and inter-agency collaboration activities. Eligible providers are local education agency (LEA) or Regional Educational Service Center (RESC) and the adult education program must be a provider of the adult high school credit diploma. Currently, nine adult education programs participate.

Positive Youth Development

Program Name: State After School Program

Program Description: Supports academic, enrichment and recreational programs either before or after school hours, weekends, summer and school vacations. After school programs are designed to complement the regular school day and provide opportunities for the families of these students to participate in educational programs. Agencies outside of the school district (community based, non-profit organizations (501-c3), and faith-based organizations) have the opportunity to operate programs in schools. The state after school initiative is available to students in grades K-12.

Program Name: Youth Service Bureaus

Program Description: Assists municipalities with maintaining and expanding youth services for young residents in grades 6-12. Supports advocacy for youth, and coordination of a comprehensive service delivery system for youth, including, but not limited to, needs assessments, prevention and intervention programs for delinquent, pre-delinquent, pregnant, parenting and troubled youth, referred by schools, police juvenile courts, adult courts, local youth serving agencies, parents and self-referral.

Appendix A: Results Based Accountability Model

The foundation of the JJPOCC RBA model are two state/community level ***quality of life results***:

- All CT children at risk of justice involvement or justice involved will realize their full potential and live safe and independent lives.[6][7]
- All state residents are safe and have a fair and responsive juvenile justice system.

Progress on these results are assessed using the following population-level (all residents, not just customers of the system) ***indicators***:

- Youth Crime Rate
- Percent of youth who are referred to court for FWSN/YIC charges
- Percent of youth who are referred to court for Delinquency/criminal charges
- Youth incarceration rate
- Percent of youth with suspension/expulsion
- Percent of youth in school or with HS diploma
- Rate of substantiated abuse and neglect
- Percent of children with access to medical services[8]
    - % with access to medical
    - % with access to dental
    - % with access to mental health

The following are ***strategic areas*** that have been developed to categorize the system's contribution to the above quality of life results:

- **System Planning and Coordination**
- **Prevention**[9]
- **Diversion (from Court)**
- **Intervention**
- **Treatment (Clinical)**
- **Re-entry/Aftercare**

System Development and Progress is Assessed Using The Following *Cross-Program, Pooled Performance Measures*:

- Percent system youth clients in school, in training, or employed

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[6] Group members suggested that this statement be reconciled with the result statement contained in the joint CSSD-DCF strategic plan.

[7] While these results statements refer to "all children at risk of court involvement" the planning efforts of this committee are focused on youth 16-17 years old, at risk of court involvement or court involved…i.e.. the population directly and immediately related to the "Raise The Age" transition

[8] Includes preventative treatement

[9] Prevention services can be provided at any stage, pre and post court referral

- Percent court involved youth that are committed or on probation
- Percent system youth clients with new convictions
- Percent system youth clients successfully completing their programs
- Percent system youth clients successfully completing supervision [probation or parole, disaggregated]
- Relative rate index [by contact type]

Performance of individual programs is assessed through an ***array of common performance measures linked to the activities/services*** provided by the program. This creates a common set of measures across programs and allows for appropriate comparisons.

How Much

- # served in program, by type of service
- % of those needing x service have access to service
- % of those needing x service that actually receive it

How Well

- Program completion rate
- Program attendance rate
- % staff with appropriate qualifications
- Average years of staff experience
- Staff/client ratio
- Cost per participant
- Cost per service
- % staff receiving on-going training
- % participants with family-oriented services [of those with identified need]

Is Anyone Better Off?

Positive outcomes for all program participants:

- % program participants engaged in positive social activities
- % program participants in employment, education, or training at exit
- % program participants with high resilience

Prevention

% of prevention program participants with no court involvement

Diversion

% of diversion participants who are diverted [not in court]

Intervention / Treatment

- % with no further court involvement
- % with adequate youth compass (or similar) scores
- % increase in standardized scores

Reentry/Aftercare

- % with no further court involvement

Data Development Agenda

Indicators:

- Percent of children with identified mental health issues
- Percent of children engaged in positive activities
- Percent children in school progressing to next grade
- Rating of confidence in justice system

System Measures

- Percent youth in positive social activities
- Percent of arrests occurring in school
- Percent youth with increase in math and reading scores

Cases Added by Defendants(16-17) Town of Residence
July 1, 2005 to June 30, 2006

Town of Residence	Total	CR	MV
BANTAM	4	1	3
BRIDGEWATER	2	1	1
COLLINSVILLE	1	1	
CORNWALL	1	1	
EAST PUTNAM	1	1	
GEORGETOWN	1	1	
GROTON LONG PT	1	1	
HADDAM NECK	1	1	
HANOVER	1	1	
HARTLAND	2	1	1
LAKESIDE	1	1	
LAKEVILLE	2	1	1
MARBLEDALE	1	1	
MARION	1	1	
NEW PRESTON	2	1	1
NORFOLK	3	1	2
NORTH FRANKLIN	1	1	
NORTH WINDHAM	1	1	
POMFRET	3	1	2
QUINEBAUG	1	1	
RIVERTON	1	1	
SALISBURY	1	1	
SOMERSVILLE	1	1	
SOUTH MERIDEN	1	1	
SOUTH WINDHAM	1	1	
SOUTHPORT	1	1	
WEST GRANBY	1	1	
WEST SUFFIELD	2	1	1
AMSTON	5	2	3
CANAAN	2	2	
EASTFORD	3	2	1
ESSEX	2	2	
HAMPTON	2	2	
KENT	5	2	3
LYME	4	2	2
MORRIS	5	2	3
NOANK	3	2	1
NORTHFIELD	4	2	2

Cases Added by Defendants(16-17) Town of Residence
July 1, 2005 to June 30, 2006

Town of Residence	Total	CR	MV
BOLTON	11	7	4
DAYVILLE	7	7	
ROXBURY	10	7	3
WOODSTOCK	9	7	2
ASHFORD	9	8	1
BARKHAMSTED	9	8	1
MARLBOROUGH	10	8	2
NORTH CANAAN	9	8	1
OLD LYME	11	8	3
QUAKER HILL	14	8	6
WESTON	15	8	7
BETHANY	14	9	5
BOZRAH	11	9	2
CANTERBURY	11	9	2
THOMPSON	11	9	2
EAST HADDAM	17	10	7
MIDDLEBURY	15	10	5
PRESTON	12	10	2
SALEM	14	10	4
LEBANON	13	11	2
STAFFORD SPRINGS	12	11	1
UNIONVILLE	20	11	9
WESTBROOK	14	12	2
BEACON FALLS	20	13	7
COS COB	15	13	2
HARWINTON	16	13	3
HEBRON	14	13	1
LISBON	13	13	
MOOSUP	18	13	5
ROCKVILLE	20	13	7
SOMERS	19	13	6
WOODBRIDGE	21	13	8
BURLINGTON	21	14	7
GRANBY	19	14	5
KILLINGWORTH	21	14	7
MIDDLEFIELD	16	14	2
NEW HARTFORD	20	14	6
STONINGTON	15	14	1

Cases Added by Defendants(16-17) Town of Residence
July 1, 2005 to June 30, 2006

Town of Residence	Total	CR	MV
MONROE	35	25	10
KENSINGTON	28	26	2
PAWCATUCK	27	26	1
MYSTIC	34	28	6
PORTLAND	31	28	3
CANTON	31	29	2
DARIEN	36	29	7
NEW CANAAN	39	29	10
ROCKY HILL	33	29	4
UNCASVILLE	33	29	4
FARMINGTON	44	30	14
BROOKFIELD	46	32	14
WILTON	45	33	12
COLCHESTER	38	34	4
NORTH HAVEN	40	34	6
SIMSBURY	45	34	11
CLINTON	45	35	10
COVENTRY	44	35	9
TERRYVILLE	41	35	6
NEW FAIRFIELD	45	37	8
DANIELSON	46	38	8
DERBY	44	38	6
WATERFORD	52	39	13
PUTNAM	45	40	5
FAIRFIELD	62	41	21
OAKVILLE	43	41	2
WETHERSFIELD	50	41	9
CROMWELL	50	42	8
SOUTHBURY	64	42	22
WATERTOWN	46	43	3
CHESHIRE	50	44	6
GUILFORD	61	44	17
TOLLAND	54	45	9
MADISON	61	46	15
EAST HAMPTON	57	50	7
WINDSOR LOCKS	60	53	7
WOLCOTT	85	56	29
PLAINVILLE	64	57	7

Cases Added by Defendants(16-17) Town of Residence
July 1, 2005 to June 30, 2006

Town of Residence	Total	CR	MV
STAMFORD	383	333	50
NEW BRITAIN	513	460	53
BRIDGEPORT	749	646	103
WATERBURY	992	909	83
NEW HAVEN	1265	1110	155
HARTFORD	1571	1390	181
COLEBROOK	2		2
EAST CANAAN	2		2
EAST HARTLAND	1		1
FALLS VILLAGE	1		1
MIDDLE HADDAM	2		2
NORTH GRANBY	2		2
PLEASANT VALLEY	1		1
ROCKFALL	1		1
SHARON	1		1
SOUTH NORWALK	1		1
WAUREGAN	1		1
WEATOGUE	2		2